Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PHYSICAL THERPAY TOS
2419 HWY 121
BEDFORD TEXAS 76021

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
THE HARTFORD UNDERWRITERS INSURANCE

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M411-1439-01

MFDR Date Received
January 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 7/15/2010, I spoke with adjuster Joyce Fishbeck regarding authorization for physical therapy for Mrs. Dibler. I asked if we needed authorization for the initial evaluation. I was told we could see Mrs. Dibler for 6 visits than send for authorization. We followed the directions given and were denied payment. I sent a fax and email to Ms. Fishbeck she has denied this information. Since this incident I am continually given this same information. I myself had a worker's compensation injury The Hartford is also our carrier I was also told this same information. I ask that you look into this policy and the information that is given out."

Amount in Dispute: $497.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Did not obtain auth per Rule 134.600 (p) for DOS in dispute."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2010, September 8, 2010, September 10, 2010 and September 13, 2010	97110	$497.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the preauthorization, concurrent review and voluntary certification of healthcare guidelines.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 14, 2010 and September 28, 2010
   - 197-198 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Procedure not approved by pre-authorization

Issues

1. Did the requestor obtain preauthorization as required by 28 TAC Rule §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes... (5) physical and occupational therapy services..."
2. Review of the documentation submitted by the requestor indicates that preauthorization was not obtained for CPT code 97110 as required by Texas Administrative Code §134.600 (p). Therefore, reimbursement for the disputed CPT code 97110 rendered on September 1, 2010, September 8, 2010, September 10, 2010 and September 13, 2010 cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.